

Testimony before the Health, Education, Labor and Pension Committee

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My name is Dr. JudyAnn Bigby, and I am the Secretary of Health and Human Services for the Commonwealth of Massachusetts. I am honored to be here with you today to represent Massachusetts and Governor Deval Patrick in offering testimony before the Health, Education, Labor and Pensions Committee about Massachusetts' initiatives related to wellness and prevention and health disparities.

I particularly want to thank Chairman Kennedy of Massachusetts for inviting me to testify today and for holding a hearing on states' public health efforts. I also want to thank Senator Michael Enzi and the other distinguished committee members for their interest in and commitment to this important topic. I look forward to hearing your insights and perspectives and answering any questions you may have.

As you know, in April 2006, Massachusetts enacted a health care reform bill designed to move the state to near-universal coverage. Thanks to Governor Deval Patrick, the Legislature and the commitment of a coalition of advocates, providers, business leaders, and committed officials in Washington like Chairman Kennedy, Massachusetts recently reported that 97.4% of our state's residents, including, as far as we can measure, 100% of children, have health insurance. We also know that more than 90% of people report that they have a regular health care provider and more report receiving preventive care.

Health Care Reform, Ch 58, was more than just a health insurance bill. Ch 58 dealt with wellness and prevention, as well as health care disparities – all issue that the

Patrick Administration is focusing on through the design and implementation of several policies. Promoting wellness and prevention has begun with our Medicaid program, MassHealth, through a wellness incentive program and the coverage of tobacco replacement drugs.. While health care disparities are addressed through a first-in-the-nation pay-for-performance program for acute hospitals.

In addition to these relatively new policies, Massachusetts has had significant success using public health approaches to reduce high cost risk factors. The Patrick Administration believes that these approaches, combined with our efforts to expand health care access throughout the state, can form a powerful model for national efforts towards universal health care.

Wellness and Prevention initiatives

Health Care Reform: More than Just Health Insurance

MassHealth Wellness Program

Section 54 of Chapter 58 requires that MassHealth collaborate with the Massachusetts Department of Public Health (DPH) to implement a wellness program for MassHealth members. It specifies five clinical domains: diabetes and cancer screening for early detection, stroke education, smoking cessation, and teen pregnancy prevention. The law mandates co-payment and premium reduction for members who meet wellness goals. However, since members do not pay significant co-payments or premiums, we have recommended alternative incentives.

The MassHealth Wellness Program works with providers to design training programs and forums to promote culturally appropriate communication with members about the importance of regular preventive health care and health risk factors. It also provides members with printed materials to help them learn about healthy lifestyle choices and the benefits of those choices.

The MassHealth Wellness Program, in collaboration with the Department of Public Health, is exploring the feasibility of developing an incentive program for MassHealth

members participating in wellness-related activities. The reward would consist of coupons for fruits and vegetables that would be used in participating grocery stores and at farmers' markets. Distribution of reward information and nutrition education would occur through the existing provider (grocery stores and farmers' markets) and staff networks for the WIC program.

Tobacco Control

On the prevention front, the Mass Tobacco Control Program partnered with MassHealth to design, promote, and evaluate the MassHealth smoking cessation benefit implemented on July 1, 2006 as part of Health Care Reform. The benefit includes group or individual counseling by smoking cessation counselors and covers nicotine lozenges, patches and other cessation medication. Utilization data indicates that **over 60,000** MassHealth subscribers have used the benefit over the first two years, representing one in three smokers. Behavioral Risk Factor Social Survey (BRFSS) data indicate that between 2006 and 2007, the smoking rate in the MassHealth population decreased from 36.1% to 33.2%, an 8% reduction in the number of smokers. Over 15,000 MassHealth members quit smoking during this period.

Preliminary data also indicate that within one year after quitting smoking, cardiovascular incidents and asthma emergency room visits declined significantly for former smokers. This decrease resulted in a dramatic reduction in health care costs in the first year alone, representing direct savings to the Commonwealth.

The latest BRFSS analysis (2006) on the correlation between health insurance and smoking prevalence indicates that those with private health insurance are half as likely to smoke as those with no insurance or MassHealth. There was no significant difference between MassHealth members and the uninsured in terms of smoking prevalence, but this data predates the addition of a smoking cessation benefit to MassHealth.

It was imperative for our state to implement effective tobacco control. Tobacco use is the leading cause of preventable death and illness in Massachusetts. More than 8,000 Massachusetts residents die each year from the effects of smoking. And though they are not smokers themselves, an estimated 1,000 or more Massachusetts adults and children die each year from the effects of secondhand smoke. In our state, tobacco kills more people each year than car accidents, AIDS, homicides, suicides and poisonings combined.

In addition to the price paid in lives lost, tobacco imposes a heavy financial burden on the Commonwealth. Smoking costs Massachusetts an estimated \$4.3 billion each year due to excess direct health care costs.ⁱ Each pack of cigarettes sold in Massachusetts costs the state an estimated \$14.22 in direct health care costs.

Beyond the initiatives directly related to Health Care Reform, the Massachusetts Tobacco Control Program works to improve public health in the Commonwealth by reducing death and disability from tobacco use.

The program has:

- a community-based smoke-free families initiative,
- a web-based youth-targeted initiative called the84.org to spread the message that non-smoking is actually the norm among teenagers,
- community smoking cessation demonstration projects targeting high-risk groups such as veterans and people in recovery,
- increased monitoring of youth sales – we have seen a decrease in the number of violations,
- produced a video targeting youth,
- initiated public information campaigns advertising our Quit Line and the dangers of second-hand smoke, and

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implemented a statewide ban on smoking in workplaces.

I am happy to report there have only been a few violations.

Reversing the Rise in Obesity

The Commonwealth has adopted a similarly comprehensive approach to tackle obesity through the Mass in Motion program, which promotes healthy eating and regular physical activity.

More than half of the Massachusetts Adult population is overweight as are a third of middle and high school students. The percentage of the population that is overweight has been increasing steadily over the last three decades. It disproportionately affects low-income populations and residents of color. In fact, almost two-thirds of adult African Americans in Massachusetts are overweight. This disproportionate impact is a result of a variety of policies and practices, which have meant that for lower income residents the most affordable and accessible foods are often the least healthful ones.

Mass In Motion is a multi-faceted program that includes:

- Regulatory changes to promote healthy eating, such as **Body Mass Index testing** of Massachusetts students in public schools in grades 1, 4, 7 and 10, as well as **menu labeling for fast food chain restaurants**;
- An Executive Order by Governor Patrick requiring Health and Human Services Agencies responsible for large food purchasing to follow strict nutritional guidelines in their food service operations. State purchases of food by these agencies runs into the tens of millions of dollars per year;

- Grants to communities to establish wellness initiatives at the local level;
- Workplace Wellness programs throughout the state and supported by a tool kit designed and tested by the Department of Public Health to help employees stay healthy, and businesses to be more productive;
- The launch of a state-sponsored website that promotes healthy eating and physical activity at home, at work, and in the community. The objective of the website is to provide simple, practical, cost-effective ways for Massachusetts' residents to:
 - Improve eating habits
 - Increase physical activity
 - Ask experts questions about improving their diet and physical exercise routine
 - Get involved in helping to build healthy communities

Mental Health Prevention Efforts

The state is also exploring public health and preventative interventions to promote mental health and to address disparities in health outcomes among individuals with mental illness.

People with mental illness experience significant health disparities with substantially increased risk of early death and significant disabling illness. Individuals with mental illness die 25 years earlier than the general population from potentially preventable and high-cost diseases such as diabetes, cardiovascular disease, respiratory illness, and lung cancer. Other high-cost risk factors among individuals with mental illness include homelessness, poverty, unemployment, incarceration, and co-occurring substance use issues.

The Commonwealth's Department of Mental Health is committed to developing comprehensive and integrated physical and behavioral health care. Enhanced integration of both physical and behavioral health results in improved health outcomes.

As a result, the Department has an extensive community provider network that coordinates medical care for mental health consumers. Benefits include improved communications for consumers through coordinators attending medical appointments and having portable medication lists.

The Department also has a strong partnership with MassHealth in the re-procurement and management of its managed care entities, which have clear requirements to coordinate physical and behavioral health care.

The Department has lead a two-year demonstration pilot with Community Mental Health Centers and Community Health Centers at six sites across Massachusetts to enhance this integration. This effort has resulted in:

- the co-location of behavioral health and primary care services,
- a centralized intake,
- a streamlined referral processes,
- on-site clinicians, and
- care managers focused on assessment and treatment of mental health disorders.

The Department of Mental Health recognizes that trauma often plays a central role in the development of mental health and substance abuse problems. The Department has coupled this with recovery-focused models of care to ensure a more complete prevention model of treatment for behavioral health and substance use issues.

The Department is recognized as a national leader in trauma-informed care, having been the first state in the country to:

- implement trauma treatment guidelines (1998),
- develop and implement a trauma assessment to be used in all state facilities (1998),
- require trauma assessment for every consumer in psychiatric care in the Commonwealth (2006), and
- continuously develop specialized tools for youth and people with intellectual and developmental challenges (2001-2008).

Many of the prevention initiatives taken at the Department of Mental Health have been quite successful and have the potential for replication on a national level.

Racial and Ethnic Health Disparities

Racial and ethnic health disparities exist nationwide. In Massachusetts, disparities exist throughout the Commonwealth, not just in urban areas. Massachusetts has disparities in health outcomes, health care quality, and in access to care:

- The black, non-Hispanic Infant Mortality Rate is twice as high as the white non-Hispanic IMR (9.4 vs. 4.3 deaths per 1,000 live births).
- The teen birth rate for Hispanic women is almost 6 times higher than for white non-Hispanics (73.2 vs. 12.9 per 1,000 women ages 15-19 years old).
- Cambodian, Central American and African mothers are less likely to receive prenatal care in their first trimester compared with mothers in other ethnic groups. (*Massachusetts Department of Public Health, Birth Outcomes 2007*)
- Blacks have a 35% higher age-adjusted mortality rate compared to whites and nearly twice the rate of Hispanics and Asians.
- Blacks have higher age-adjusted death rates for heart disease, cancer, stroke, diabetes, HIV/AIDS, homicide, MVAs and other injuries. (*2001*

Massachusetts Department of Public Health report Massachusetts Health Status indicators by Race and Hispanic Ethnicity)

- Blacks have higher hospital discharge rates for hypertension, stroke, and cardiovascular disease.
- Blacks and Hispanics have three to four times higher rates for asthma discharges compared to whites. *(2001 Massachusetts Department of Public Health report Massachusetts Health Status indicators by Race and Hispanic Ethnicity)*In one health care setting, insured Blacks with diabetes were less likely than whites to be prescribed cholesterol lowering drugs when indicated and were less likely to have their diabetes well controlled *(Sequist TD et.al Arch Intern Med 2006;166:675-81)*
- In 2007, 5.7% of all Massachusetts residents did not have health insurance. However, Hispanics and Black Non-Hispanic residents have higher rates of uninsurance when compared to other races and ethnicities.

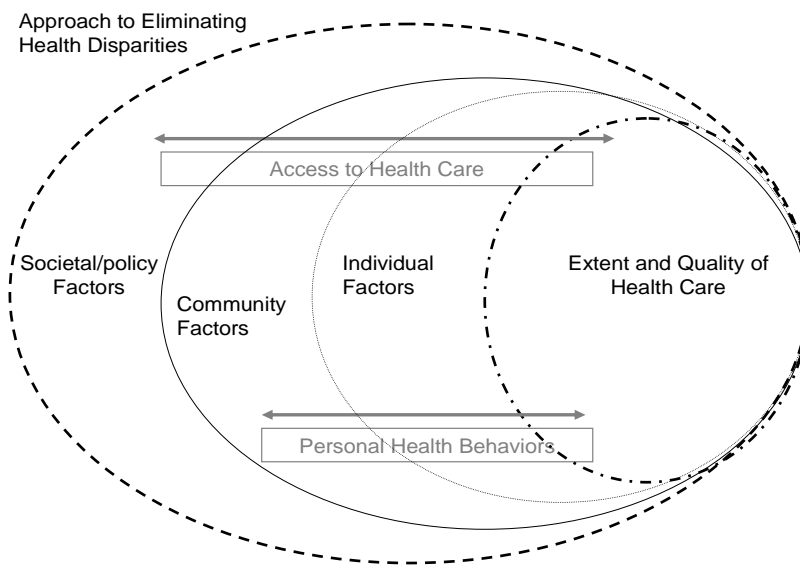
Commonwealth's Approach to Eliminating Health Disparities

In 2004, the Legislature established a special commission to study racial and ethnic health disparities. The Commission issued its report in the summer of 2006 and aligned their recommendations into 4 categories:

- 1) access to health care,
- 2) health care quality and delivery,
- 3) workforce development and diversity, and
- 4) social determinants.

The Patrick Administration and the Disparities Council, a council created as part of Health Care Reform, are working together to model racial and ethnic disparities solutions on the recommendation put forward by the Commission. We are undertaking a number of initiatives.

We know that addressing health disparities requires actions and initiatives inside and outside of the health care system. Disparities result from a variety of intersecting factors that range from public policy to individual behaviors to design of the health care system. We must address all factors to achieve health equity.



To address these disparities, the Patrick Administration has taken a number of proactive and innovative steps, including:

- Distributing \$1 million in new funding to support a wide variety of community-based efforts to eliminate disparities. More than 30 grants were awarded to local agencies to establish culturally and linguistically appropriate health care services, training programs for health care workers, and support systems for residents of color who face challenges in navigating the health care system.
- Implementing a regulation that requires all hospitals in the state to gather and report accurate and consistent information on the race and ethnicity of all patients. This first-in-the-country regulation is producing information that will soon be published in a Department of Public Health report highlighting

patterns of access to care and identifying facilities were additional efforts are needed.

- The publication of several reports that highlight disparities in particular health areas – such as HIV.
- The formation of an Office of Health Equity at both the Department of Public Health and the Executive Office of Health and Human Services to insure that multiple programs and agencies adopt policies that target disparities.

ACTIVITIES IMPLEMENTED UNDER CH 58

Pay-for Performance Program to Promote Health Care Equity

Beginning in October 2007, MassHealth implemented a pay-for-performance program in acute care hospitals. One of the first of its kind in the country, the program rewards positive outcomes based on established clinical measures in maternity and newborn care, respiratory care (including pediatric asthma control), surgical care, and health disparities.

In the first year of the program, health disparities were addressed structurally, using established Culturally and Linguistically Appropriate Services (CLAS) standards to assess how widely institutions have operationalized practices designed to address the needs of racial, ethnic and linguistic population groups that experience unequal access to health services. This year, the program will continue to assess structural CLAS standards and will expand to reward hospitals that reduce or eliminate identifiable disparities on the clinical indicators by race and ethnicity.

This promising program is only one example of how we can use quality-based purchasing strategies to address health disparities. I urge the Committee to remember, as more sophisticated quality initiatives and pay-for-performance programs expand, that the elimination of health care disparities remain an essential element of quality in our health care system.

ⁱ Massachusetts Department of Public Health. *Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): Massachusetts 2006*.